DH-74

INSTRUCTIONS FOR COMPLETION

Complete as follows:

1. AGREEMENT NUMBER	BSHCN use only.
2. O.A. VENDOR NUMBER	BSHCN use only.
3. PROVIDER NAME	Enter the complete name of the agency/business.
4. NAME OF AUTHORIZED REPRESENTATIVE	Individual designated by agency.
5. SIGNATURE OF PROVIDER OR REPRESENTITIVE	Enter original signature of Provider or Representative
6. DATE	Enter the date form is completed.
7. FEDERAL TAX I.D. OR SOCIAL SECURITY NUMBER	Enter the federal tax identification number or the social security number that the provider will use to file federal income tax.
8. TYPE OF PROVIDER	Mark the box for type of provider if applicable. Write in type if "other".
9. PAYMENT MAILING ADDRESS	Enter the provider’s address where payment is to be mailed to. (Street/City/State/Zip)
10. STATE LICENSE NUMBER (IF APPLICABLE)	Enter the agency/individual state license number if applicable.
11. TELEPHONE NUMBER	Enter the phone number of the agency/individual provider.
12. MINORITY OWNED/OPERATED	Mark the box yes or no if minority owned or operated business.
13. PROVIDER ENROLLMENT APPROVED	BSHCN use only.